STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	006106	A. BUILDING _____ B. WING _____	07/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED HOSPITAL INDIANAPOLIS	1700 W 10TH ST INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit is for a State hospital complaint investigation. Complaint: #IN00106483 Substantiated; no deficiencies related to allegation are cited. Survey Date: 07/17/12 Facility: # 006106 Surveyor: Linda Dubak, R.N. Public Health Nurse Surveyor Kindred Hospital Indianapolis, Inc. is in compliance with 410 IAC 15-1.5-6, Nursing service, Indiana Hospital Licensure Rules. QA: claughlin 08/06/12	S 000		